OFFICE OF VICTIM SERVICES
Focusing on a brighter future

PERSONAL INJURY COMPENSATION
APPLICATION
JD-VS-8PI Rev. 12/07

SECTION ONE - VICTIM INFORMATION

Name of victim (last, first, middle) | Home telephone | Work telephone

Address | Cell telephone | Age

City | State | Zip | Birth date | Sex

Primary language of victim

Would you like to be contacted via email? ❍ Yes ❍ No Email _____

SECTION TWO - CLAIMANT INFORMATION *(Complete if different from victim)*

Name of claimant (last, first, middle) | Home telephone | Work telephone

Address | Cell telephone | Age

City | State | Zip | Birth date | Sex

Primary language of claimant

Would you like to be contacted via email? ❍ Yes ❍ No Email _____

Claimant relationship to victim:

❍ child ❍ spouse ❍ parent ❍ grandchild ❍ grandparent ❍ spouse's parent ❍ stepparent
❍ brother ❍ sister ❍ half brother ❍ half sister ❍ step child ❍ adopted child ❍ administrator
❍ party to a civil union ❍ other (ie. DCF case worker) _____

FOR OFFICE USE ONLY | Claim Number | Claims Examiner

SECTION THREE - CONTACT PERSON *(Person to contact if victim/claimant cannot be reached)*

Name of contact person (last, first, middle) | Relationship to claimant

Address | City | State | Zip

Home telephone | Work telephone | Cell telephone

SECTION FOUR - ATTORNEY REPRESENTATION *(Complete only if represented by an attorney)*

Name of attorney (last, first, middle) | Name of firm

Address | City | State | Zip

Work telephone | Fax | Juris number

SECTION FIVE - CRIME INFORMATION

Type of crime: ❍ assault ❍ sexual assault ❍ robbery with injury ❍ dui ❍ hit and run ❍ other _____

Briefly describe the crime:

If victim of sexual assault, was the sexual assault medical examination and evidence collection completed within 72 hours of the assault? ❍ yes ❍ no

If yes, name of hospital/healthcare facility | Date of examination

Date of crime | Address where crime occurred

Date crime was reported to police | Police department to which crime was reported

Police department incident number | Name(s) of assisting officer(s)

Was the crime reported to the police within five days? ❍ yes ❍ no (If not, please explain)

SECTION FIVE - CRIME INFORMATION (CONTINUED)

Has an arrest(s) been made? ❍ yes ❍ no ❍ unknown _____
Name of offender(s), if known

Has the offender(s) been arraigned in court? ❍ yes ❍ no ❍ unknown _____ _____
If yes, court location Docket number

SECTION SIX - MEDICAL/COUNSELING INFORMATION

Are you applying for compensation of unreimbursed medical, dental and/or mental health counseling expenses? ❍ yes ❍ no
If yes, please briefly describe the physical or emotional injuries that resulted from the crime:

_____

_____

_____

List all providers that gave treatment, include hospital, doctors, dentists, mental health counselors, ambulance, radiology and prescriptions (drugs and eyeglasses). Attach additional sheets if necessary. If available, please enclose copies of bills.

Provider's Name	Address	Telephone

Will there be additional treatment? ❍ yes ❍ no ❍ unknown

If yes, provider's name _____

SECTION SEVEN - EMPLOYMENT INFORMATION

Were you employed at the time of the crime? ❍ yes ❍ no If yes, are you applying for wage loss compensation? ❍ yes ❍ no

If yes, complete the following section (if self-employed, see SECTION SEVEN A).

Name of employer _____ Telephone _____

Address _____ Hours worked per week _____

City _____ State _____ Zip _____ $ Wage per hour _____ $ Tips, bonuses per week _____

Dates absent from work due to crime related injuries From _____ To _____ Total hours absent _____

If you have missed more than one week of work, please provide a doctor's statement verifying length of time you were unable to work.

Name of doctor _____ Telephone _____

Address _____ City _____ State _____ Zip _____

In order for OVS to consider any salary loss, please check any source listed below from which you received financial support.

sick leave	❍ yes ❍ no	Workers Compensation	❍ yes ❍ no	other (please list)
vacation	❍ yes ❍ no	unemployment compensation	❍ yes ❍ no	
union/fraternal insurance	❍ yes ❍ no	Social Security disability	❍ yes ❍ no	_____
disability benefits	❍ yes ❍ no	state Medicaid/city public assistance	❍ yes ❍ no	_____

SECTION SEVEN A - SELF-EMPLOYMENT INFORMATION

If you were self-employed at the time of the crime, please submit a copy of your tax return and documentation (W-2 form, 1099 form, etc.) for the year before the crime. If you have missed more than one week of work, please provide a doctor's statement verifying length of time you were unable to work.

Name of doctor _____ Telephone _____

Address _____ City _____ State _____ Zip _____

In order for OVS to consider any salary loss, please check any source listed below from which you received financial support.

Workers Compensation	❍ yes ❍ no	disability benefits	❍ yes ❍ no	other (please list)
unemployment compensation	❍ yes ❍ no	Social Security disability	❍ yes ❍ no	_____
union/fraternal insurance	❍ yes ❍ no	state Medicaid/city public assistance	❍ yes ❍ no	_____

SECTION EIGHT - INSURANCE & OTHER COLLATERAL SOURCE INFORMATION

Have bills been paid or will bills be paid by any of the following sources?

yourself	❍ yes ❍ no	Veterans' Administration	❍ yes ❍ no
private health insurance	❍ yes ❍ no	life insurance	❍ yes ❍ no
Medicare	❍ yes ❍ no	Workers' Compensation	❍ yes ❍ no
state Medicaid	❍ yes ❍ no	other (please list) _____	

Name of primary medical insurer | Telephone | Policy number

Address | City | State | Zip

Name of secondary medical insurer (*if applicable*) | Telephone | Policy Number

Address | City | State | Zip

Please note: If you checked yes to any of the above, medical and mental health counseling bills must be submitted to that source before OVS can consider reimbursement.

SECTION NINE - RESTITUTION AND CIVIL ACTION

Did the crime involve motor vehicles? ❍ yes ❍ no (If yes, please provide your automobile insurance policy declarations page.)

Did the court order the defendant to make restitution? ❍ yes ❍ no

Have you filed or do you intend to file a civil action? ❍ yes ❍ no (If yes, please complete below.)

Name of attorney | Name of firm

Address | City | State | Zip

SECTION TEN - STATISTICAL INFORMATION

How did you find out about the crime victims' compensation program?

❍ police	❍ Infoline/211	❍ prosecutor/state's attorney	❍ private attorney
❍ poster/brochure	❍ public service announcement	❍ community advocate	❍ Office of Adult Probation
❍ friend/acquaintance	❍ medical provider	❍ OVS victim advocate	❍ OVS webpage
❍ telephone book	❍ social service provider	❍ hospital	❍ other

Submission of information regarding race/ethnic background or disabilities is voluntary.

❍ white ❍ black/African American ❍ hispanic ❍ native Hawaiian/pacific islander

❍ american indian/alaskan native ❍ asian ❍ other ❍ unknown

Were you disabled prior to crime? ❍ yes ❍ no

SECTION ELEVEN - STATEMENT OF FACTS AND AUTHORIZATION

The undersigned certifies that the information herein is true to his or her best knowledge, information and belief and hereby authorizes any hospital, physician(s) or other person(s) who attended, examined, or rendered services to _____ (victim's or family member's name), any employer(s) of the victim, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge thereof, to furnish to the OVS or its representative any and all information with respect to the incident leading to the victim's personal injuries and the victim's or family member's application made for compensation.
A photocopy of this authorization will be considered as effective and valid as the original.

I,_____ , authorize OVS to disclose any information in its possession, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General and to private attorneys retained by OVS or the victim, and to communicate freely with any of the foregoing when such disclosure and communications are necessary pursuant to Connecticut General Statutes sections 54-208(e), 54-212 and 54-215.

Further, I understand that OVS may be entitled to receive proceeds that an offender has been ordered to pay the victim as restitution ordered by the State of Connecticut's criminal court system. This is in accordance with Connecticut General Statutes section 54-215.

I understand that any recovery of my losses from the offender resulting from a civil action that I have brought entitles OVS to reimbursement of two-thirds of any compensation awarded to me and that OVS shall have a lien on the recovery pursuant to Connecticut General Statutes section 54-212. I understand that I must notify OVS of the filing of any such civil action within thirty days of the filing of the action in court.

Further, I understand that pursuant to Connecticut General Statutes section 54-212, OVS shall be subrogated to any cause of action I have against the offender. A civil action may be brought on behalf of OVS by the Attorney General or by a private attorney hired by OVS. OVS shall furnish me with a copy of the action within thirty days of the filing of the action in court.

Applicant signature (*Parent or guardian must sign if victim is a minor or an incompetent adult*) Date

Please return this form to:
Office of Victim Services
225 Spring Street
Wethersfield, CT 06109

Contact OVS at:
1-888-286-7347 (Toll-free compensation line - CT only)
860-263-2761
www.jud.ct.gov/crimevictim